Team Comments and Questions Regarding Georgia's 1115 demonstration proposal to Promote Early Intervention and to Conduct Research and Evaluation Regarding HIV/AIDS Care

Budget Neutrality and Data Systems (Please see attached document on Budget Neutrality relevant data points)

1. The footnote on page 48 indicates that the State has conducted an analysis of its ADAP program to ensure the financial viability if this demonstration is approved. We would like to either see this study or hear more information about it. We are concerned that the growth of the waiver will outstrip funding for ADAP. In addition, we would like to know how this demonstration will affect access to ADAP for individuals that do not qualify for it (i.e. an FPL between 235% -300%).

2. Please provide a walk-through of the assumptions/formulas used to derive the costs to Medicaid with and without the waiver.

3. Page 17, "Eighty-five percent of ADAP recipients in Georgia are currently on HAART." Please explain the 85%. According to the HRSA ADAP Branch estimates, currently approximately 100% of the ADAP recipients are on HAART. It may be, for example, if individuals are not receiving all of the HAART drug therapies from ADAP they may be receiving them from various other sources, for example, the VA or other systems of health care.

4. Page 6, is the decrease in AIDS cases in Georgia of 66% (from 2233 in 1994 to 768 in 1999) due to HAART consistent with the earlier statement that many individuals are receiving sub-optimal HAART? Since the State does not currently have HIV reporting, can Georgia track an accurate number of new HIV infections by risk category and demographics? Does the State have plans to move to an HIV reporting system so that they can obtain a more objective measure of those individuals likely served by this waiver? If not, how does the State plan to review new HIV infections?

Eligibility, Outreach, and Enrollment

5. On page 6, the State mentioned that the percentage of AIDS cases among homosexuals and IV drug users had declined and the number of HIV cases among heterosexuals, especially African-Americans and women, were increasing. How does the State account for this? What outreach efforts is the State undertaking to educate and to promote prevention and treatment among these communities where the number of cases is increasing? Also, please explain the appropriate media outlets that will be used in the outreach efforts under the demonstration project (page 57).

6. Besides ADAP, the Medicaid data system, and the Grady Memorial Hospital Infectious Disease Center (IDC), what other avenues is the State looking at to ensure that all possible HIV risk groups are being reached? (page 16)

7. Page 47, the State indicates that Medicare beneficiaries will not be covered under the waiver. We understand that this may be a way for the State to increase the likelihood of cost effectiveness; however, since approximately 22% of Grady Hospital's HIV patients are Medicare eligible, this will leave a significant portion of the population without the benefits of the Centers of Excellence and the intensive case management which promotes treatment adherence. Since the Medicare beneficiaries should not be too expensive relative to the other services covered under the waiver (because Medicare will cover most of them) and ADAP would be paying for HAART, would the State ever consider covering Medicare beneficiaries?

8. Is the eligibility criteria for Medicaid under the Section 1931 eligibility group the same as the eligibility criteria for TANF?

9. Page 16: Under ADAP, GA states that "State regulations limit the program to persons with CD4 counts under 500 cells per cubic millimeter..." Will this regulation be changed to allow those individuals in the demonstration with CD4 counts greater than 500 to access ADAP if they and their physician choose to begin HAART?

10. P. 57, Outreach: Will the State consider targeting outreach efforts to correctional facilities, including juvenile detention facilities, and possibly half-way houses?

11. Can an HIV positive Medicaid eligible enrolled in GBHC choose to receive care at an HIV Center of Excellence?

Benefits

12. Please describe how beneficiaries will access the Centers of Excellence.

13. Page 51, the State proposes to provide a tailored set of mental health and substance abuse services through an existing Community Service Board (CSB) program. Will this be the same set of services currently provided in Medicaid or expanded services? If it is to mirror the Medicaid program, what has been the experience of Medicaid with actual access to the services and the success and quality of the services? Is there an adequate provider network?

14. The waiver indicates that laboratory costs for an HIV-positive Medicaid patients in FY 99 was $392. This would indicate that Georgia is not yet reimbursing for resistance testing. Since studies not only show that the tests preserve the limited repertoire of antiretroviral drugs, but also are cost effective, will the State consider covering these tests in the demonstration and the regular Medicaid program?

15. Needs assessments should include an assessment of HIV risk behaviors. HIV prevention counseling services should include prevention case management (PCM) or multi-session intensive counseling for persons who have difficulty initiating or maintaining safer sex and needle-sharing practices. (p. 50) Please address.

Program Structure and Delivery System

16. How does the State plan to assure that there will be a bidder for the Centers of Excellence in each of the 19 districts and that there are experienced providers to provide or oversee care?

17. Please explain how providers will be required to account for receipts under the demonstration project separately from the Medicaid reimbursement? (page 55)

Monitoring

18. What is the State proposing regarding provider monitoring?

19. How does the State foresee the Centers of Excellence monitoring adherence to drug regimens?

20. The State should consider monitoring and/or measuring at least the following indicators of HIV care:
    - CD4 measurement at six months
    - Viral load (HIV plasma RNA) testing at six months
    - Offering ART to patients with CD4 counts less than 350
    - Offering of PCP prophylaxis to patents with CD4 counts less than 200

21. The State should consider using the following HIV prevention indicators in its quality assurance program:

    - The proportion of beneficiaries assessed for HIV risk behaviors
    - The proportion of beneficiaries receiving HIV risk reduction counseling
    - The proportion of beneficiaries presenting with a new episode of a sexually transmitted disease

In addition the State should consider monitoring the degree to which the provision of prevention services, such as prevention counseling and partner notification services, are documented in the chart.

General Comments

22. In collaboration with the George Washington University's Center for Health Services Research and Policy, CDC and HRSA developed "Sample Purchasing Specifications for HIV Infection, AIDS, and HIV-Related Conditions". These prevention and care specifications were developed for use in Medicaid managed care contracts and may be useful in drafting contracts with the HIV Centers of Excellence. They are on GWU's web site at www.gwu.edu/~chsrp.

23. P. 50, paragraph 2, line 4: The diagnosis of a sexually transmitted disease or pregnancy should also be SOURCE program "triggers". The case management should include periodic inquiries about safer sex and needle-sharing practices (if appropriate).

24. P. 52, Centers of Excellence: Providing prevention services within the context of care is preferable to providing referrals for prevention services. Consideration should be given to

approaching the health department about the possibility of stationing prevention counselors on-site at Centers of Excellence.

25. Please provide journal articles which support the following claims:
- A 20% savings if a Center of Excellence approach is used.

- The transitional probability distributions used for early and late HAART with particular stress on those in a later HIV stage reverting back to a less severe stage.

26. The assumption that every patient "who qualifies for HAART will receive it" is optimal; however, many people are unable to bear the side effects and choose not to begin drug therapy until in late stage disease. Many active substance abusers are not good candidates for HAART, and a few are on salvage therapies that may not be recommended HAART therapies. The latest publication from follow-up 2 in the HCSUS states that only 53 percent of the people not lost to follow-up or death were receiving HAART. Please address the State's approach.

Operational Protocol

27. P. 50, paragraph 2, line 7: Prevention case management should be included in the protocol for the HIV case management benefit. Georgia's HIV/AIDS Needs Assessment documented the need to expand prevention case management.

28. Page 73, how will the demonstration ensure that mental health and substance abuse services are readily available to those who need them? What specific methods will the providers use to increase adherence, and what documentation will be required of providers to show effectiveness?